1605 Kingsley Ave
Orange Park, FL 32073
Phone: (904) 264-9555 Fax: (904) 269-9013

Women's Care FLORIDA
North Florida Ob-Gyn

Orange Park Division
H&P Form

1680 Eagle Harbor Parkway
Orange Park, FL 32003
Phone: (904) 264-9555 Fax: (904) 215-7960

Patient's Name_____ **DOB:** _____/_____/_____ **Date:** _____
Age:_____ **Race** _____ **Referred by:** _____
Reason for this Appt_____

Menstrual History

Last Period _____ **Age at onset** _____ **Regular** ☐Yes ☐No **Flow** ☐ Light ☐ Mod ☐ Heavy
Cycle Length _____ days (from start to start) Duration: _____ days **Postmenopausal** ☐Yes ☐No
Date of last Pap smear: _____ **Current Birth Control Method** _____

☐ Bleeding between menses ☐ Vaginal discharge ☐ PMS
☐ Bleeding after intercourse ☐ Vaginal irritation ☐ Large Clots
☐ Night Sweats / Hot Flashes ☐ Irregular Bleeding ☐ Pains / Cramps
☐ Other: _____

Family History:

Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
High Blood Pressure		Tuberculosis		**Cancer**	
Kidney Problems		Alzheimer's / Dementia		Breast/Age	
High Cholesterol		Depression / Suicide		Melanoma	
Diabetes		Blood Clots		Ovarian	
Heart Disease		Osteoporosis		Colon	
Stroke		Birth Defect		Other	

Allergies

Item	Reaction

Medication

Drug	Dose	How Often

Medication

Drug	Dose	How Often

Past Medical History:

Have you ever had a blood transfusion? ☐ Yes ☐ No
Would you have a blood transfusion to save your life? ☐ Yes ☐ No
Have you ever had any of the following illnesses? Check all that apply.

☐ Heart Trouble ☐ Osteoporosis ☐ Chronic Fatigue ☐ Breast Problems / Nipple Discharge
☐ Kidney / Bladder Problems ☐ DES Exposure ☐ Anemia ☐ Hemorrhoids
☐ High Blood Pressure ☐ Dysplasia / HPV ☐ Cholesterol ☐ Anesthesia Problems
☐ Low Blood Pressure ☐ Fibroids ☐ Hepatitis ☐ Heart Murmur / MVP
☐ Thyroid Problems ☐ Pelvic Prolapse ☐ Anxiety ☐ Prophylatctic Antibiotics before Procedures
☐ Migraine Headaches ☐ Depression ☐ Varicose Veins ☐ Polysystic Ovarian Syndrome
☐ Rectal Bleeding ☐ Endometriosis ☐ Diabetes ☐ Genital Herpes ☐ Genital Warts
☐ Stomach Trouble (Ulcer / IBS) ☐ Seizures ☐ Blood Disorders ☐ Abnormal Pap Smear

STD Type? _____ Cancer Type? _____ Are you HIV Positive? _____

Surgical History: (Including Hospitalizations)

Date	Procedure

Pregnancies _____ Miscarriages _____ Abortions____

Date	Delivery Type	Sex	Lbs/Oz	Complications

Smoker? ☐ **No** ☐ **Former Smoker** ☐ **Current Smoker (packs per day_____)**
Social History: Use of alcohol Drinks per week_____ **Illegal Drugs** ☐Yes ☐No
Marital History: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Currently sexually active ☐No ☐Yes / ☐ **With opposite sex** ☐ **Same sex** / **Same Partner** ☐ **Yes** ☐ **No**
History of Domestic Abuse: ☐ No ☐ Yes explain: _____